Bureau of Quality Improvement Services (BQIS)

Mortality Communication | **Period ending 03/31/2012**

BQIS

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Mortality Communication Purpose

- It is the expectation of BQIS that providers will familiarize themselves (and staff) with this information through training efforts.
- The following issues were identified during mortality reviews completed during the third quarter of fiscal year 2012 (January through March 2012).
- While the data presented may pertain to comorbid conditions that are not attributable to the cause of death, the risk involved with these conditions warrant further examination.
- This communication is not intended to provide specific medical recommendations and interested parties should seek further clarification from trained medical professionals.

Risk Plans

The topic of risk plans has been discussed in previous issues of this mortality review communication and can be found at http://www.in.gov/fssa/ddrs/2635.htm. As mortality reviews are conducted, there are still times when risk plans (or the lack of them) are identified as a concern. Based on cases reviewed this quarter, the following issues were noted at least once and determined to be important issues to share with providers, case managers, and other interested stakeholders to review, share with pertinent team members, and take proactive steps as appropriate. This quarter's focus includes the following:

- If a risk issue is an active issue on the Health/Safety Indicator Tool, an individual-specific risk plan needs to be developed, implemented, and staff trained. It is not sufficient just to include the risk factor in the ISP. Remember, the risk plan is a written set of guidelines and instructions for everyone who is supporting a person who is receiving services.
- If a family member provides care, there should be documentation that indicates how the family member addresses the risk issue.
- If a person experiences repeated falls (with or without an injury), the fall prevention plan should be reviewed (and revised as needed) and/or staff training repeated. If multiple falls are occurring, the current fall prevention plan is not effective as written or trained. If falls are occurring due to lack of implementation or some other variable, these variables need to be addressed and resolved.
- The dining plan/choking prevention plan and the ISP should clearly state that the plan is to be followed any time a person is ingesting food and/or liquids. This includes medication administration, snacks, etc. Staff should be trained on this requirement and the agency should have a system to monitor implementation.
- A team needs to provide ongoing support to a person receiving services and his/her natural supports to encourage development of and compliance with risk plans. In the case of a consumer not wanting to follow a risk plan, the team might want to have the consumer sign a negotiated risk agreement.
- Providers should ensure that individual-specific protocols are developed, implemented, and staff are timely trained on the protocols if a person requires restraints (e.g., medical, positioning, etc.). The protocol should include the required supervision level (e.g., line of sight) and length of time to be used.
- An individual-specific risk plan that includes some potential signs/symptoms of problems that might occur for a person with a G-/J-tube is critical. Just as important, staff should be trained on implementing the plan.
- In the event that a person has a change in the type of tube (G- to J - for example), the risk plan needs to be revised in a timely fashion, staff need to be timely trained on the changes, the team needs to have a plan to monitor the effectiveness of the tube, and a PCP visit needs to be scheduled to follow-up. It is imperative that adequate health care oversight is in place.
- If a person received a G-/J- tube (either the first one or a replacement tube), as part of the hospital discharge instructions, the hospital staff/physicians need to know the type of setting the person is returning to (e.g., group home with 24/7 staff, nursing services not available in the home, etc.). It is possible that the person might need to go to a different setting after placement of a G/J tube.
- Providers are encouraged to review their operating policy and individual-specific risk plans to ensure the complications of malpositioned tubes are addressed (e.g., what to watch for, who to contact, etc.). Please refer to the Malpositioned Feeding Tubes section of this report.
- If a person has a prescription for Coumadin (Warfarin), an individual-specific risk plan should be developed and implemented to ensure staff have the information readily available to be knowledgeable about the risk issues, signs/symptoms, and what actions to take in the event of a problem. Please refer to the Coumadin Monitoring section of this report.

In the case of a consumer not wanting to follow a risk plan, the team might want to have the consumer sign a negotiated risk agreement.

Health Care Coordination

Changes in status that are not recognized or are not responded to in a timely manner can lead to an increased need for ER visits and/or hospital admissions as well as the potential for death.

This topic has also been discussed in previous issues of the mortality review communication and can be found at http://www.in.gov/fssa/ddrs/2635.htm. As mortality reviews are conducted, there continue to be times when concerns are identified in this area. Based on cases reviewed this quarter, the following issues were noted at least once and determined to be issues that would be beneficial to share with providers, case managers, and other interested stakeholders in order to review, share with pertinent team members, and take proactive steps as appropriate. This quarter's focus includes the following:

- If medications are changed, the changes should be timely communicated to any other physician/specialist providing care to ensure the specialist treating a particular condition (e.g., the neurologist in charge of treating the seizure disorder) is aware of and agrees with the change recommended/ordered by another physician.
- Regular staff training on the importance of recognizing/responding to changes in status in a timely manner is strongly encouraged. Please refer to BQIS resource material - http://www.in.gov/fssa/files/recognizing_change_in_status.pdf, http://www.in.gov/fssa/files/responding_to_change_in_status.pdf, http://www.in.gov/fssa/files/signs_and_symptoms.pdf.

Changes in status that are not recognized or are not responded to in a timely manner can lead to an increased need for ER visits and/or hospital admissions as well as the potential for worsening health or death.

While the reasons for an ER visit or a hospital admission can be varied, the underlying factor is that a change in status (real or perceived) was noted. A variety of fact sheets and resource materials relative to recognizing and responding to changes in health status and medical conditions/situations are available on the BQIS website (http://www.in.gov/fssa/ddrs/2635.htm). Providers are encouraged to incorporate these materials into their operating policies/procedures and individual-specific risk plans and ensure staff are trained and have implemented them.

Table 1. Number of Emergency Room Visits and In-Patient Hospitalizations Reported.

Description	Jan-12	Feb-12	Mar-12	Grand Total
Emergency Room Visit - Medical	810	797	853	2460
In-Patient Hospitalization - Medical	245	233	246	724
Emergency Room Visit - Psychiatric	109	86	88	283
In-Patient Hospitalization - Psychiatric	74	62	61	197

Staff Training

"This (training) system includes the type of training provided, the name and qualifications of the trainer, the duration of training, the date(s) of training, the signature of the trainer verifying the satisfactory completion of training by the employee, and the signature of the employee (460 IAC 6-16-3)."

Staff training and implementation is critical. While it would be nice to think that one well-planned staff training session would be sufficient, reality tells us differently. Ongoing training is important. Previous issues of this communication have also addressed the topic of staff training. Based on cases reviewed this quarter, the following issues were noted at least once and determined to be issues that would be beneficial to share with providers, case managers, and other interested stakeholders in order to review, share with pertinent team members, and take proactive steps as appropriate. Focus items this quarter include:

- Provider agencies are encouraged to review their operating policy/procedure to ensure staff are timely trained on individual-specific risk plans (e.g., at time of initial development, at time of update, and on a regular (at least annually) basis), all staff receive annual training on required topics (e.g., incident reporting, documentation requirements, etc.), a qualified trainer conducts the training, and staff are trained to DDRS core competencies.
- Provider agencies are required to have a system for documenting the training of each employee. This system includes the type of training provided, the name and qualifications of the trainer, the duration of training, the date(s) of training, the signature of the trainer verifying the satisfactory completion of training by the employee, and the signature of the employee (460 IAC 6-16-3).

Concern over the quality of documentation was also noted during the provider compliance reviews (CERT) conducted during the period of 10/01/2011 through 03/31/2012. During this period, 17 (14%) of the providers reviewed did not have training records that included all required components.

Staff Training (cont.)

Training materials for specific individuals should include an understanding of any individual-specific risk plans, any health care/nursing care plans, significant diagnoses, basic facts and knowledge about a disease process in that individual, any other specific needs of the individual, and side effects of medications prescribed for that individual.

- Provider agencies should ensure that both general training and individual-specific training are updated periodically and that there is a system in place to ensure all staff complete these updates (460 IAC 6-14-4, 460 IAC 6-16-3).
- Providers should review a sample of training records to ensure the procedures are being followed. As part of the sampling process, providers should review the training documents to ensure that similar documentation is available from each home. A consistent system should be utilized across the provider's agency.

Medication Administration

The overall topic of medication administration covers many subareas and the accuracy and success of each subarea is dependent on the others. Some of the issues identified in this quarter's mortality review cases are addressed in the bullets below.

- Medications administered on a daily basis are prescribed for a specific diagnosis determined by a physician (primary care physician, specialist, or psychiatrist). It is recommended that the Medication Administration Record includes the diagnosis for any prescribed medication and/or treatment. When the diagnosis is included on the MAR, the association between the diagnosis and the prescribed medication is evident. This assures all concerned (e.g., primary care physician, nursing staff, direct support professionals, house managers/supervisors, health paraprofessionals, families, etc.) that the person's medication regimen has been reviewed and helps to identify if there are any "unnecessary" medications that might have duplicate orders (brand or generic name) for administration on a routine basis. Having the diagnosis(es) associated with each medication, allows the team to group medications by purpose (e.g., all psychotropics can be grouped according to the psychiatric illness(es) being treated, etc.). The team can more readily identify polypharmacy for psychiatric care along with other medical diagnoses such as hypertension. Staff should be knowledgeable about the name of the medication (brand and generic) along with the purpose of the medication and the potential side effects. The provision of a diagnosis for administration of a medication would not necessarily be done for PRN medications which are often used in comfort care for minimizing signs and symptoms of an illness. The reason (sign or symptom) should be clearly indicated for the PRN use.
- Review operating policy/procedure regarding medication administration (e.g., timely updating MAR, including diagnosis associated with medication, handwritten entries on MAR, monitoring for side effects, etc.).
- Review the agency's operating policy/procedure regarding medication administration (6 rights of medication administration, MAR entries, adding meds, discontinuing meds, completing a cross check of meds to ensure accurate meds and doses, monitoring for side effects of medication, etc.).

Six Rights of Medication Administration

Medication
Route
Time
Client
Dosage
Documentation

- If the MAR includes the reason for the drug, it helps the staff giving the medication (and the staff performing a QA check) potentially catch issues.
- If the MAR includes both the brand name and the generic name (e.g., generic name given for brand name, (e.g., Valproic acid given for Depakene, Inderal given for Propranolol, Risperidone, given for Risperdal, etc.), it would potentially alert staff that the same medication is being given just under a different name.
- The provider agency should ensure their QA system includes:
  1. A method to ensure the correct prescribed drugs are available in the correct dosages and listed on the MAR correctly;
  2. A method to ensure discontinued drugs are removed from the MAR and the drugs are physically removed from the home;
  3. Frequency that drugs/MARs are checked;
  4. A method to ensure the correct drugs are sent in the correct dosages and listed on the MAR correctly;
  5. A method to ensure discontinued drugs are not sent and are not listed on the MAR.

During the period from 10/01/2011 through 03/31/2012, 10 (8%) of the providers reviewed with the CERT were found to have an insufficient Quality Assurance process for medication errors.

- Does a pharmacy review occur? If so, how often? What types of issues are reviewed?
- If there is a new medication, take the prescription and the current MAR to the pharmacy. At that point in time, ask "are there any medications on this MAR that should be discussed with the doctor and/or discontinued?" This would ensure the pharmacy has all the up-to-date medications listed, especially important if more than one pharmacy had been utilized.
- If a medication is discontinued at the same time as a new one is started, take a copy of the physician's order to the pharmacy so the pharmacy is clear about what is the current medication regimen ordered by the physician.
- Providers should review their operating procedures regarding narcotics. Is there a check in/check out system, is there a system to ensure narcotics are accounted for at least daily; do staff work in multiple homes where narcotics are available? Providers should review a sample of narcotics/records of same to ensure the procedures are being followed.

Table 2. Number and Types of Medication Errors Reported

Description	Jan-12	Feb-12	Mar-12	Grand Total
Medication error, missed dose, not given	425	401	426	1252
Medication error, wrong dose	138	120	110	368
Medication error, wrong medication	69	62	42	173
Medication error, given outside window	27	30	23	80
Medication error jeopardizing health and safety	3	4	2	9
Medication error, wrong route	1	1	0	2
Grand Total	663	618	603	1884

Obtaining Adaptive Equipment

At least one death reviewed this quarter revealed that adaptive equipment was not available for a person with an identified need. Providers are encouraged to review their own operating policy/procedure to ensure that the process for teams to timely identify a person's need for adaptive equipment and the process to timely obtain the equipment is clearly addressed.

Wellness

People receiving services have some of the same challenges as the rest of the population in regards to maintaining wellness. There was at least one death reviewed this quarter where the person had behavior/habits that were detrimental to their health. Teams are encouraged to provide regular education/information regarding the risks and/or dangers of certain behaviors (e.g., smoking, chewing tobacco, obesity, etc.) to the person receiving services and look for creative ways to improve and/or maintain health in these areas. There are several excellent online resources available as well as the person's primary care physician.

Resources

- www.sc.edu/healthycarolina/pdf/facstaffstu/genwellness/WaysToPromoteWellness
- www.cdc.gov/nchs/health_people/hp2010/hp2010_focus_areas.htm
- www.cdc.gov/tobacco/basic_information/health_people/index.htm
- www.healthypeople.gov/2020/default.aspx
- www.healthystates.csg.org/NR/rdonlyres/E42141D1-4D47-4119-BFF4-A2E7FE81C698/0/Trends_Alert.pdf

Lapse in Medicaid

There are times when a person's Medicaid coverage might lapse thus potentially affecting his/her ability to receive supports, medical care and/or prescriptions. There was one case reviewed this quarter where this appeared to have occurred. The team is encouraged to obtain the date Medicaid will lapse for each person and identify a couple of key people to work with family members (when applicable) to ensure all documentation is timely submitted (and followed up with) so a lapse in Medicaid does not occur. It is also recommended that a couple of people are identified to be responsible for retaining a copy of the submitted documents on file (documentation of what was submitted and the date of submission), and for easy access if re-submission necessary (note – some documents might require evidence of notarization, require the original, etc.).

Coumadin Monitoring

When a person is prescribed Coumadin (Warfarin), it is important that a risk plan be developed and training completed on the risk plan for all staff who are caring for that person. Although there are several potential serious adverse effects associated with Coumadin, the discussion here will only focus on the serious risk of bleeding.

Coumadin thins the blood so that it will not clot readily. The therapeutic effect of Coumadin is tested by measuring a PT (Protime) and INR (International Normalized Ratio). There is a range for these test results that is considered therapeutic (depending on the diagnosis). If the levels of these tests fall below this, then the Coumadin loses its effectiveness in treating the diagnosis for which it was prescribed (pulmonary embolism, blood clot in leg, preventing clots from adhering to artificial heart valves, etc.). If the levels of these tests exceed these, there is an increased tendency for side effects. The further the actual levels are beyond the therapeutic range, the more at risk the person is for serious side effects. Even in the therapeutic range, a person can have significant side effects/complications.

Staff caring for a person on Coumadin should ensure that the person is tested on a strict schedule through the primary care physician, specialist, or Coumadin clinic, and results are communicated back to the provider of record, along with an interpretation and any change in orders/plans from the physician (or physician extender) in charge. It is imperative that the person does not miss appointments for blood draws concerning Coumadin.

For more information on Coumadin monitoring, please refer to the Risk Planning Resource posted through the BQIS at http://www.in.gov/fssa/ddrs/2635.htm

Malpositioned Feeding Tubes

Malpositioned Tube: A tube for which the tip is no longer in the stomach or small intestine, but instead in the peritoneal cavity. Early diagnosis of a Malpositioned feeding tube can be life saving. Delays in recognition may result in extended illness and/or death.

For all staff/family caring for a person with a feeding tube, it is recommended that an in-service be provided regarding the use and care of the tube. Staff should not be involved in care and management of feeding tubes without thorough training and documentation of competency of the skills needed in tube feeding and tube maintenance. Training includes a variety of issues, including assessment of the individual before, during, and after feeding.

For more information on Malpositioned Feeding Tubes, please refer to the Risk Planning Resource posted through the BQIS http://www.in.gov/fssa/ddrs/2635.htm

Choking vs. Aspiration

The term choking can be divided into two different categories. There is external choking, by strangulation. This can be accidental, as by restraint use, the neck being wedged such as between a restraint and bedrail, etc. so that the airway is cut off. It can be intentional, either self-inflicted or inflicted by another person. External choking will not be discussed in this communication.

The term choking is also identified when internally the airway is acutely closed off by food, fluid, medication, stomach contents from vomiting or regurgitation/reflux or an inedible object (from pica). It is an acute asphyxiation. The person may be revived, with or without permanent sequelae. It can happen to someone without a history of dysphagia. A person with dysphagia is at increased risk for choking. Fluoroscopic video swallow studies assist in determining the safest types of textured foods and thickened liquids to be offered to the person to prevent acute and chronic aspiration. Since acute aspiration can occur with anything that is placed in the mouth, this texture of solids and thickening of liquids also applies to whenever medication is administered.

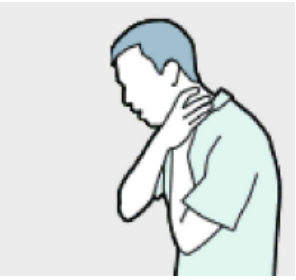
For instance, if the dining plan indicates a pureed diet and honey thickened liquids, tablets should be crushed and made into a paste or "**slurry**" consistent with a pureed diet, and liquids should be thickened to the prescribed consistency.

If the dining plan calls for a specific positioning, then that position should be present at the time of medication administration. Pica of sufficient volume can also cause an acute obstruction. Choking can also occur with those categorized as having unsafe eating habits – those with an extremely rapid rate of putting large quantities of food in the mouth. It also includes those who do not chew solids sufficiently, and attempt to swallow large unchewed pieces of food. Choking can happen with those who have vomited large amounts, or had regurgitation that reached the trachea and refluxed into the lungs. If the volume is sufficiently large to block the airway, it causes an acute asphyxiation, which leads to significant morbidity and mortality if not immediately reversed by a Heimlich maneuver, forceful cough, immediate suctioning, etc.

Table 3. Number of Choking Episodes Requiring Intervention Reported.

Description	Jan-12	Feb-12	Mar-12	Grand Total
Choking with Intervention	17	13	19	49

The term aspiration is much broader. It includes the event of choking with acute asphyxiation, but also includes chronic aspiration. If a person aspirates smaller amounts of food, fluid, medication, or stomach contents into his/her lungs, he/she is at increased risk of a chemical pneumonitis, reactive airway disease (asthma) response, and/or aspiration pneumonia/bacterial pneumonia. Significant recurrent aspiration pneumonia can lead to permanent lung damage. Aspiration pneumonia and secondary bacterial pneumonia can lead to death. Triggers can often be identified during mealtime, such as coughing, and tearful eyes, which assist the team in identifying possible aspiration. These episodes are generally not sufficient to block the airway, and the person usually recovers. However, triggers are a sign of potential worsening dysphagia with aspiration and are an indication for the need of additional testing. Some people have no triggers, those with 'silent aspiration.' They may only be identified by recurrent severe aspiration pneumonia with significant hypoxia needing repeated hospitalizations. The entire spectrum from acute asphyxiation (choking) to those with triggers during meals to those with recurrent aspiration from severe dysphagia or severe reflux are included under the broader term of aspiration.



"Slurry"

Some foods, such as breads, cakes, cookies, muffins, biscuits, or other crumbly foods, do not puree well and can be softened and thickened using a slurry mixture. A slurry mixture also helps food stick together (www.GInutrition.virginia.edu).

Pain Medication / Management

There has been at least one death reviewed during the last 12 months where issues were identified regarding pain medication/management. The bullets below are intended to share areas of concern and potential action steps to eliminate/reduce the likelihood of a similar situation.

- Ensure the physician/dentist prescribing the pain medication/comfort medication has a complete list of routine and prn medications currently being given to the person.
- Ensure the physician/dentist has a full list of current diagnoses. A person with a history of restrictive lung disease, for instance, may have serious complications with medications that may cause drowsiness.
- If there is uncertainty about the safe use or choice of pain medication, ask for a pre-operative clearance or second opinion to assist in the decision-making. The goal is the person's safety during any preparation for the procedure, during the procedure, and following the procedure.
- If the person is routinely prescribed psychotropics or other medications (allergy medications, etc.), which may cause drowsiness, consider asking the pharmacist to review for drug-drug interactions and provide information for the safest dosage (e.g., is a lower dose appropriate and effective?) and schedule (e.g., is every 6 hours safer than every 4 hours?).

"When giving pain medication, it is also important to implement a pain assessment tool, to verify effectiveness and also to ensure the medication is having minimal side effects."

1. To ensure the pharmacist has the most up-to-date information for the person, take a current copy of the MAR to the pharmacist for review.
2. Document the results of the discussion as guidance for training of staff.

- Extreme caution should be used when considering the administration of a chemical restraint while being provided pain medication, as the drug interaction may raise the risk of significant side effects and complications. This should not occur without prior review and authorization by the PCP/psychiatrist.

1. If behaviors become violent and uncontrolled following a procedure, this may be a sign of insufficient pain control.
2. If the person's behaviors are normally significant to the point of being part of the target behaviors included in the BSP, and the person is observed to have an absence or minimal behaviors, but instead has an unusually "quiet" day, this may be an indication of too much pain medication.
3. The side effects of sedation may be an indication that the pain management needs to be adjusted to reduce side effects and potential complications (e.g., falls, anorexia, hypoxia, etc).

- If the procedure (such as a dental procedure) could potentially alter intake of food or fluid after the procedure, it is recommended that an intake sheet record all food and fluid per shift until healing occurs.

1. Staff may need training on how to record the percentage of food/meal or volume of fluid ingested per shift.
2. Without training, the log will be inaccurate and incomplete.

- Consideration for reduction in dosage should be given to those with a history of sleep apnea.
- Obtain vital signs (e.g., pulse, respiratory rate, blood pressure, pulse oximetry, temperature with indication of whether axillary (under the arm), oral, tympanic (ear), rectal, etc.) at routine intervals (every 4-8 hours if otherwise stable) while on pain medication and document in a vital sign log.

1. Documenting in a progress note can be done, but changes can more readily be noted if a vital sign log sheet is completed.
2. Further, for nursing review, faxing one or two pages is more efficient than faxing several pages of narrative.
3. It is recommended that the vital signs be recorded immediately at the time of measurement in a log per shift, so the results are readily available to arriving staff. If the person subsequently sees the PCP or goes to the ER while the log is being kept, it is important to take a copy of the log with the person and that the information is shared with the physician.

- If someone is scheduled for a dosage of pain medication but is asleep, it suggests pain management has been effective and it may be best not to awaken the person for a dose of pain medication.

1. If the person had been sleeping, and not in pain, awakening him/her may make them feel pain.
2. If a person had been sleeping for a while, awakened and given pain medication on an empty stomach, the person may become nauseated and vomit. If he/she is sleeping or groggy when this happens, this increases the risk that the person may aspirate.

- Excessive or deep sleep in which a person is difficult to arouse may suggest that too much pain medication is being administered. This needs to be communicated to the agency nurse and to the PCP for recommendations.
- If the person had dental work for which the pain medication is administered, caution is advised.

1. Depending on the dental procedures, there may be swelling in the mouth, and the swelling may make it more difficult to swallow saliva normally.
2. If there is blood in the mouth, this will add to the volume needing to be swallowed successfully.
3. Additionally, the blood may pool in the stomach and contribute to nausea.
4. If there was a local anesthetic given, the mouth cavity and tongue may not be able to function normally until the anesthetic effect goes away.
5. Adding a pain medication may provide comfort, but may worsen the potential temporary difficulty swallowing or add to the nausea.

- It is recommended that when there are plans for dental procedures such as dental extractions or other procedures, or when a person will be given local anesthetics, that there be discussion with the dentist concerning the risks and benefits of pain management.

1. This conversation and planning should be completed prior to the dental procedure.
2. It is important for the PCP/specialist/dentist to determine which medications should be held the day of the procedure.
3. There are also some medications that require being held several days in advance.
4. Whether the procedure will require the person to be NPO (nothing by mouth) for several hours prior needs to be clarified and documented in writing.
5. Ask the PCP/specialist/dentist to provide guidance on when to make someone NPO.
6. Recommendations should include whether water can be administered, as well as the volume of water (especially needed if medications are to be given).
7. If adverse behaviors are possible due to the NPO status, or limited water intake, the team should meet prior to the procedure, with the behaviorist, to create a BSP addendum or ISP addendum with clear instructions to staff on how to prevent or minimize adverse behaviors, lack of cooperation, etc.
8. Ensure that dental recommendations are not in conflict with the speech pathology recommendations. Any post-operative orders should be clarified prior to the procedure and differences addressed between the dentist and speech pathologist. The case manager needs to ensure that the speech pathologist agrees with the dental post-operative recommendations. For instance, if using a straw is found to be unsafe by a fluoroscopic video swallow, but is ordered by the dentist, then the dentist needs to be aware of the speech therapy report and discuss other options with the speech pathologist (directly or through the case manager, PCP, etc.).

- When giving pain medication, it is also important to implement a pain assessment tool, to verify effectiveness and also to ensure the medication is having minimal side effects, and is not excessive in side effects. For instance, if a person's gait or balance becomes unstable, or a person has difficulty eating/swallowing, this needs to be documented and urgent communication with the PCP is indicated to re-evaluate the treatment, and consider an order for a medication change or dosage change.

1. Documentation of the PCP communication or PCP's office communication, and attempts at communication are advised.

- Staff need to be trained on how to use pain assessment/measurement tools correctly in order to obtain accurate results.

1. A risk plan for post-operative care and a risk plan for pain management should be in place prior to the procedure with staff training completed by the date of the procedure.
2. Staff not trained should not participate in the person's post-operative care. The training should include knowledge of the pain medications being ordered and the side effects to observe for and track.

- The provider should be aware of the plans for the person's procedure, the date of the procedure, that pain management is being implemented, and have a system (fax, e-mails, phone calls/messages) in place to review the vital sign log and pain assessment log at frequent intervals determined by the person's health status, the person's routine medications, the medical/dental procedure for which pain management is indicated, and the amount and type of pain medication.